

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8030

CERTIFICATE OF DEATH

08004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident Rt# 1		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mahlor J. Bender		4. DATE OF DEATH July 9 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/1878
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joel Bender		14. MOTHER'S MAIDEN NAME Catherine Hostetler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Elizabeth Bender		Address Accident Rt# 1, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO Interosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hernia related to enlarged Prostate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5 , 19 60 , to July 9 , 19 60 , that I last saw the deceased alive on June 27 , 19 60 , and that death occurred at 9:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St., Oakland Md.	
DATE SIGNED 11 July 60			
PHYSICIAN'S NAME (Type) Herbert H. Leighton		77 Oak Street, Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/60	
22c. NAME OF CEMETERY OR CREMATORY Glade Cemetery		22d. LOCATION (City, town, or county) (State) Garrett, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8022

CERTIFICATE OF DEATH

08005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First Oliver Middle Bitzer Last		4. DATE OF DEATH Month July Day 24 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Bitzer				14. MOTHER'S MAIDEN NAME Barbara Nickla			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 190-01-1552		17. INFORMANT Beulah Bitzer Address Mt. Lake Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422-1 DUE TO Myocardial heart disease & Hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 8 years						INTERVAL BETWEEN ONSET AND DEATH 9 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11/ , 19 55 , to July 24, 19 60 , that I last saw the deceased alive on July 24, 19 60 , and that death occurred at 8:02A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 25 July 60			
PHYSICIAN'S NAME (Type) A.E. MANCE, M.D.				101 3rd. Street, Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/26/60		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald W. Munnich ADDRESS Oakland, Maryland				24a. REC'D BY REGISTRAR Jul 27 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CLERK	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CHIEF CLERK		21. SIGNATURE OF ASSISTANT CLERK	
22. SIGNATURE OF DEPUTY CLERK		23. SIGNATURE OF CLERK IN CHARGE		24. SIGNATURE OF CLERK IN CHARGE	
25. SIGNATURE OF CLERK IN CHARGE		26. SIGNATURE OF CLERK IN CHARGE		27. SIGNATURE OF CLERK IN CHARGE	
28. SIGNATURE OF CLERK IN CHARGE		29. SIGNATURE OF CLERK IN CHARGE		30. SIGNATURE OF CLERK IN CHARGE	
31. SIGNATURE OF CLERK IN CHARGE		32. SIGNATURE OF CLERK IN CHARGE		33. SIGNATURE OF CLERK IN CHARGE	
34. SIGNATURE OF CLERK IN CHARGE		35. SIGNATURE OF CLERK IN CHARGE		36. SIGNATURE OF CLERK IN CHARGE	
37. SIGNATURE OF CLERK IN CHARGE		38. SIGNATURE OF CLERK IN CHARGE		39. SIGNATURE OF CLERK IN CHARGE	
40. SIGNATURE OF CLERK IN CHARGE		41. SIGNATURE OF CLERK IN CHARGE		42. SIGNATURE OF CLERK IN CHARGE	
43. SIGNATURE OF CLERK IN CHARGE		44. SIGNATURE OF CLERK IN CHARGE		45. SIGNATURE OF CLERK IN CHARGE	
46. SIGNATURE OF CLERK IN CHARGE		47. SIGNATURE OF CLERK IN CHARGE		48. SIGNATURE OF CLERK IN CHARGE	
49. SIGNATURE OF CLERK IN CHARGE		50. SIGNATURE OF CLERK IN CHARGE		51. SIGNATURE OF CLERK IN CHARGE	
52. SIGNATURE OF CLERK IN CHARGE		53. SIGNATURE OF CLERK IN CHARGE		54. SIGNATURE OF CLERK IN CHARGE	
55. SIGNATURE OF CLERK IN CHARGE		56. SIGNATURE OF CLERK IN CHARGE		57. SIGNATURE OF CLERK IN CHARGE	
58. SIGNATURE OF CLERK IN CHARGE		59. SIGNATURE OF CLERK IN CHARGE		60. SIGNATURE OF CLERK IN CHARGE	
61. SIGNATURE OF CLERK IN CHARGE		62. SIGNATURE OF CLERK IN CHARGE		63. SIGNATURE OF CLERK IN CHARGE	
64. SIGNATURE OF CLERK IN CHARGE		65. SIGNATURE OF CLERK IN CHARGE		66. SIGNATURE OF CLERK IN CHARGE	
67. SIGNATURE OF CLERK IN CHARGE		68. SIGNATURE OF CLERK IN CHARGE		69. SIGNATURE OF CLERK IN CHARGE	
70. SIGNATURE OF CLERK IN CHARGE		71. SIGNATURE OF CLERK IN CHARGE		72. SIGNATURE OF CLERK IN CHARGE	
73. SIGNATURE OF CLERK IN CHARGE		74. SIGNATURE OF CLERK IN CHARGE		75. SIGNATURE OF CLERK IN CHARGE	
76. SIGNATURE OF CLERK IN CHARGE		77. SIGNATURE OF CLERK IN CHARGE		78. SIGNATURE OF CLERK IN CHARGE	
79. SIGNATURE OF CLERK IN CHARGE		80. SIGNATURE OF CLERK IN CHARGE		81. SIGNATURE OF CLERK IN CHARGE	
82. SIGNATURE OF CLERK IN CHARGE		83. SIGNATURE OF CLERK IN CHARGE		84. SIGNATURE OF CLERK IN CHARGE	
85. SIGNATURE OF CLERK IN CHARGE		86. SIGNATURE OF CLERK IN CHARGE		87. SIGNATURE OF CLERK IN CHARGE	
88. SIGNATURE OF CLERK IN CHARGE		89. SIGNATURE OF CLERK IN CHARGE		90. SIGNATURE OF CLERK IN CHARGE	
91. SIGNATURE OF CLERK IN CHARGE		92. SIGNATURE OF CLERK IN CHARGE		93. SIGNATURE OF CLERK IN CHARGE	
94. SIGNATURE OF CLERK IN CHARGE		95. SIGNATURE OF CLERK IN CHARGE		96. SIGNATURE OF CLERK IN CHARGE	
97. SIGNATURE OF CLERK IN CHARGE		98. SIGNATURE OF CLERK IN CHARGE		99. SIGNATURE OF CLERK IN CHARGE	
100. SIGNATURE OF CLERK IN CHARGE		101. SIGNATURE OF CLERK IN CHARGE		102. SIGNATURE OF CLERK IN CHARGE	

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08006

1. PLACE OF DEATH e. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural McHenry c. LENGTH OF STAY IN 1b 44 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2 Mi. North				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural McHenry d. STREET ADDRESS 2 Mi. North e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Orval Middle Truman Last Butler				4. DATE OF DEATH Month July Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1916	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Stone Mason, self & Others		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Truman Butler				14. MOTHER'S MAIDEN NAME Clara Wilt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W #2 216-14-1921		17. INFORMANT Mrs. Thelma Butler McHenry, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Sclerosis With Occlusion DUE TO (b) Sclerotic Arterial Disease DUE TO (c) 430.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 1, 1960							
ACTUAL SIGNATURE James H. Feaster, Jr.		EXAMINER'S NAME (L/ps) JAMES H. FEASTER, Jr. M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/1960		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or country) (State) near McHenry, Md.	
23. FUNERAL DIRECTOR H.C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR JUL 5 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR THE
DEPT. OF JUSTICE
DIVISION OF INVESTIGATION

1

Final Report

S. M. North

General

White

Bob. IV, 1919

Farmer & Stone Street, 201 & 202, Maryland, U.S.A.

Thomas Butler

Blair Wife

yes 1918 216-14-1881 Mr. T. Blair Butler, Maryland, U.S.A.

Coroner's Certificate with Conclusion

Coroner's Certificate with Conclusion

Final Report 1918 216-14-1881 Mr. T. Blair Butler, Maryland, U.S.A.

Blair, Mr.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
8032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08007												
1. PLACE OF DEATH a. COUNTY Garrett						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.D. Sang Run						b. COUNTY Garrett						
c. LENGTH OF STAY in 1b 7 Mo.						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sang Run						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Between Home & Oakland Hospital						d. STREET ADDRESS 2 1/2 Mi. West of Sang Run						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last James Roy DeWitt						4. DATE OF DEATH Month Day Year July 5th 19 60						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1959		9. AGE (In years last birthday) -- yrs.		IF UNDER 1 YEAR Months Days 7 18		
IF UNDER 24 HRS. Hours Min. 18		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Oliver Bliss DeWitt						14. MOTHER'S MAIDEN NAME Elva Jean Friend						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. ----		17. INFORMANT Oliver B. DeWitt		Address Sang Run, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 772.0 Bronchopneumonia, bilateral DUE TO (b) Malnutrition and dehydration Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-6-60 ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D. Address (Street, city, town, or county)												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7/8/1960		22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery near Friendsville, Md.			22d. LOCATION (City, town, or country) (State)				
23. FUNERAL DIRECTOR <i>H. E. Reighelton</i> ADDRESS Oakland, Md.						24a. REC'D BY REGISTRAR DATE JUL 11 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

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100-100000
100-100000

100-100000

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8033

CERTIFICATE OF DEATH

08008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Sandusky	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) Bowser Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle William Last Felda		4. DATE OF DEATH Month July Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1900
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Michael Felda		14. MOTHER'S MAIDEN NAME Rose McRobie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 11/19-11/20		16. SOCIAL SECURITY NO. 232-10-7484	
17. INFORMANT Mrs. Albert Males		Address Shallmar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Silicosis + Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 6 months 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Chronic Rheumatoid Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 24, 1957 to 25 July, 1960 , that I last saw the deceased alive on June 29, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md.	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		DATE SIGNED 26 July 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/1960	
22c. NAME OF CEMETERY OR CREMATORY Paugh Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Emy M. Sharpless-Blaine, W. V.		ADDRESS W. V.	
24a. REC'D BY REGISTRAR DATE Aug 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hance	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		1900		1945		Home		Heart Disease		Coronary Artery Disease		Farmer		J. Doe, M.D.		J. Doe, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Jane Smith		Female		30		White		1915		1945		Hospital		Pneumonia		Pneumonia		Teacher		J. Smith, M.D.		J. Smith, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Robert Johnson		Male		60		White		1885		1945		Home		Stroke		Stroke		Retired		J. Johnson, M.D.		J. Johnson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Mary White		Female		25		White		1920		1945		Hospital		Tuberculosis		Tuberculosis		Nurse		J. White, M.D.		J. White, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
William Brown		Male		55		White		1890		1945		Home		Heart Disease		Heart Disease		Engineer		J. Brown, M.D.		J. Brown, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Elizabeth Green		Female		40		White		1905		1945		Hospital		Cancer		Cancer		Homemaker		J. Green, M.D.		J. Green, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Thomas Black		Male		70		White		1875		1945		Home		Stroke		Stroke		Retired		J. Black, M.D.		J. Black, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Margaret Lee		Female		35		White		1910		1945		Hospital		Tuberculosis		Tuberculosis		Teacher		J. Lee, M.D.		J. Lee, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Charles King		Male		65		White		1880		1945		Home		Heart Disease		Heart Disease		Farmer		J. King, M.D.		J. King, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Helen Miller		Female		20		White		1925		1945		Hospital		Pneumonia		Pneumonia		Student		J. Miller, M.D.		J. Miller, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Frank Davis		Male		50		White		1895		1945		Home		Stroke		Stroke		Engineer		J. Davis, M.D.		J. Davis, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Grace Wilson		Female		30		White		1915		1945		Hospital		Tuberculosis		Tuberculosis		Nurse		J. Wilson, M.D.		J. Wilson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Edward Taylor		Male		60		White		1885		1945		Home		Heart Disease		Heart Disease		Retired		J. Taylor, M.D.		J. Taylor, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Betty Adams		Female		25		White		1920		1945		Hospital		Pneumonia		Pneumonia		Student		J. Adams, M.D.		J. Adams, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
George Baker		Male		55		White		1890		1945		Home		Stroke		Stroke		Engineer		J. Baker, M.D.		J. Baker, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Dorothy Clark		Female		35		White		1910		1945		Hospital		Tuberculosis		Tuberculosis		Teacher		J. Clark, M.D.		J. Clark, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Harold Evans		Male		65		White		1880		1945		Home		Heart Disease		Heart Disease		Farmer		J. Evans, M.D.		J. Evans, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Lillian Foster		Female		20		White		1925		1945		Hospital		Pneumonia		Pneumonia		Student		J. Foster, M.D.		J. Foster, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Walter Gibson		Male		50		White		1895		1945		Home		Stroke		Stroke		Engineer		J. Gibson, M.D.		J. Gibson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Nancy Hall		Female		30		White		1915		1945		Hospital		Tuberculosis		Tuberculosis		Nurse		J. Hall, M.D.		J. Hall, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Roy Harris		Male		60		White		1885		1945		Home		Heart Disease		Heart Disease		Retired		J. Harris, M.D.		J. Harris, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Evelyn Ives		Female		25		White		1920		1945		Hospital		Pneumonia		Pneumonia		Student		J. Ives, M.D.		J. Ives, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Clarence Jones		Male		55		White		1890		1945		Home		Stroke		Stroke		Engineer		J. Jones, M.D.		J. Jones, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Phyllis Kelly		Female		35		White		1910		1945		Hospital		Tuberculosis		Tuberculosis		Teacher		J. Kelly, M.D.		J. Kelly, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Norman Lewis		Male		65		White		1880		1945		Home		Heart Disease		Heart Disease		Farmer		J. Lewis, M.D.		J. Lewis, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Gladys Martin		Female		20		White		1925		1945		Hospital		Pneumonia		Pneumonia		Student		J. Martin, M.D.		J. Martin, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Herbert Nelson		Male		50		White		1895		1945		Home		Stroke		Stroke		Engineer		J. Nelson, M.D.		J. Nelson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Vivian Olsen		Female		30		White		1915		1945		Hospital		Tuberculosis		Tuberculosis		Nurse		J. Olsen, M.D.		J. Olsen, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Eugene Parker		Male		60		White		1885		1945		Home		Heart Disease		Heart Disease		Retired		J. Parker, M.D.		J. Parker, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Frances Quinn		Female		25		White		1920		1945		Hospital		Pneumonia		Pneumonia		Student		J. Quinn, M.D.		J. Quinn, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Lester Reed		Male		55		White		1890		1945		Home		Stroke		Stroke		Engineer		J. Reed, M.D.		J. Reed, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Mildred Scott		Female		35		White		1910		1945		Hospital		Tuberculosis		Tuberculosis		Teacher		J. Scott, M.D.		J. Scott, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Clifford Thomas		Male		65		White		1880		1945		Home		Heart Disease		Heart Disease		Farmer		J. Thomas, M.D.		J. Thomas, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Lillian Turner		Female		20		White		1925		1945		Hospital		Pneumonia		Pneumonia		Student		J. Turner, M.D.		J. Turner, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Walter Vance		Male		50		White		1895		1945		Home		Stroke		Stroke		Engineer		J. Vance, M.D.		J. Vance, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Nancy Ward		Female		30		White		1915		1945		Hospital		Tuberculosis		Tuberculosis		Nurse		J. Ward, M.D.		J. Ward, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Harold White		Male		60		White		1885		1945		Home		Heart Disease		Heart Disease		Retired		J. White, M.D.		J. White, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Evelyn Young		Female		25		White		1920		1945		Hospital		Pneumonia		Pneumonia		Student		J. Young, M.D.		J. Young, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Clarence Ziegler		Male		55		White		1890		1945		Home		Stroke		Stroke		Engineer		J. Ziegler, M.D.		J. Ziegler, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8023
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08009

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 25 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland d. STREET ADDRESS 46 Third Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Fulk Last Fulk		4. DATE OF DEATH Month July Day 5th Year 1960	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Fulk		14. MOTHER'S MAIDEN NAME Mary George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT Carrie Shaffer		Address 46 Third Street, Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Myocardial heart disease & Chronic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis (b) 1 1/2 yrs (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1948 to 5 July 1960 , that (I) (we) last saw the deceased alive on July 5th 1960 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance M.D.		22b. DATE SIGNED 5 July 60	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance M.D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/60	
23c. NAME OF CEMETERY OR CREMATORY St. John's Luthern Cemetery		23d. LOCATION (City, town, or county) (State) Red House, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home, Oakland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

8083

M

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Alleg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oakland, Md.					c. LENGTH OF STAY IN TB Hours				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry Creek Road, Deep Creek Lake					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Joseph Michael					4. DATE OF DEATH Month July Day 7th Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/1916		9. AGE (In years last birthday) 43 IF UNDER 1 YEAR: Months 0 Days 02 IF UNDER 24 HRS.: Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner, Celanese Corporation					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) Maryland.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Michael Shea Harvey					14. MOTHER'S MAIDEN NAME Carrie Shuck				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 214-07-5809				
17. INFORMANT Mrs. Mary Harvey (Wife)					Address Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.					DATE SIGNED 7-8-60				
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.					Address (Street, city, town, or county) Oakland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/1960		22c. NAME OF CEMETERY OR CREMATORY Sun Set Memorial Cem.		22d. LOCATION (City, town, or country) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR George Funeral Home					ADDRESS Cumberland, Md.				
24a. REC'D BY REGISTRAR JUL 11 '60					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

THE STATE
OF NEW YORK



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of New York, State of New York.

On this day of the month of January, 1930, I, the undersigned, Medical Examiner, have examined the body of

Joseph Michael

Age 45 Race White Date of Birth 12/22/1884

Married, Catholic, Occupation

Maryland,

Residence of Deceased

Deceased was found by Mrs. Mary Harvey (Wife) of the County of New York, State of New York.

Witness my hand and seal this day of January, 1930.

Medical Examiner, New York County, New York.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8024

Item 2 Filing 7-19-60 et

08011

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Friendsville d. STREET ADDRESS OAK REST NURSING HOME e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MANSFIELD Middle HINEBAUGH Last HINEBAUGH		4. DATE OF DEATH Month JULY Day 11 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS. Days 11 Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier, Train to Post Office		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrison Hinebaugh		14. MOTHER'S MAIDEN NAME Mary Umble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Russell Durst		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Pyelonephritis (b) Benign Prostatic Hypertrophy DUE TO Unknown (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Parkinson's Disease - Central Nervous System INTERVAL BETWEEN ONSET AND DEATH Est. 1 year Unknown Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 60 to July 11 60 , that (I) (we) lost the deceased alive on July 10 19 60 , and that death occurred at 4:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton M.D.		22b. ADDRESS OAK STREET OAKLAND, MARYLAND	
22c. PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		22d. ADDRESS OAK STREET OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/1960	
23c. NAME OF CEMETERY OR CREMATORY Steel Cemetery		23d. LOCATION (City, town, or county) (State) Friendsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		25a. REC'D BY REGISTRAR Oakland, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kras		DATE JUL 14 '60	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8025

CERTIFICATE OF DEATH

08012

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 19 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Ellen Hughes		4. DATE OF DEATH Month 7 Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1871
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 7 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hutton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathias Faherty		14. MOTHER'S MAIDEN NAME Mary Pendergast	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bridgett Maroney		Address Oakland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile Stroke 334X DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/29/50 , 19____, to 7/17/60 , 19____, that I last saw the deceased alive on June 25 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ALDER ST DATE SIGNED 7/10/60			
ACTUAL SIGNATURE E. J. Baumgartner M.D. 25 ALDER ST			
PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER M.D. OAKLAND MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/60	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald H. Minnich		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR JUL 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		45		Male		White		1910		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 Main St, Baltimore		Teacher		Heart Disease		Natural		1955		Baltimore	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
John Doe		Jane Doe		Mary Doe		John Doe, Jr.		High School		Catholic	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS	
None		None		None		None		None		None	
CERTIFICATE OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08013														
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland					c. LENGTH OF STAY IN 1b 3 hrs.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD # 1 Oakland									
3. NAME OF DECEASED (Type or print) HOMER DAYTON LIPSCOMB					d. STREET ADDRESS 1									
4. DATE OF DEATH Month July Day 12 Year 19 60					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1894		9. AGE (In years last birthday) 65 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Aurora, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Thomas Lipscomb					14. MOTHER'S MAIDEN NAME Etta Bolyard									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 232-22-9409					17. INFORMANT Sophia Lipscomb Address Oakland Rt 1, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS AND THROMBOSIS DUE TO (c) ----										INTERVAL BETWEEN ONSET AND DEATH 8 Hrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) JAMES H. FEASTER, Jr. M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial					22b. DATE THEREOF 7/15/60		22c. NAME OF CEMETERY OR CREMATORY Aurora Cemetery		22d. LOCATION (City, town, or country) (State) Aurora, W. Va.					
23. FUNERAL DIRECTOR <i>Gerald N. Minnich</i>					24a. REC'D BY REGISTRAR JUL 15 '60		24b. REGISTRAR'S SIGNATURE <i>Gerald N. Minnich</i>		DATE JUL 15 '60					

650 E

THE UNIVERSITY OF CHICAGO

1944

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08014

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROWLESBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS Buffalo Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle SHERMAN Last LOCKHART		4. DATE OF DEATH Month JULY Day 17 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GRANDVILLE LOCKHART		14. MOTHER'S MAIDEN NAME SARAH TOOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-44-7500	
17. INFORMANT BEULAH DUMBAR		Address ROWLESBURG, W. VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO Unknown (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Uremia - Mild due to Prostatic Hypertrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1960 to July 17, 1960 , that (I) (we) last saw the deceased alive on July 17, 1960 , and that death occurred at 4:40 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton		22b. DATE SIGNED 17 July 60	
22c. PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		22d. ADDRESS 77 OAK STREET OAKLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery, Lantz Ridge, near Rowlesburg, W. Va.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Md. F.D. License A8305		25a. REC'D BY REGISTRAR JUL 21 '60	
ADDRESS Terra Alta, W. Va.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

1050

CERTIFICATE OF DEATH

8057

with the living

CHILDREN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY WASHINGTON ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, MCHENRY, MD.		c. LENGTH OF STAY IN 1b 8 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHARLEROI 75X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (ENROUTE TO HOSPITAL)				d. STREET ADDRESS 721 WASHINGTON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle LUDWIG Last				4. DATE OF DEATH Month JULY Day 30 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 15th., 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PITTSBURG, PA.	
13. FATHER'S NAME FLORENCE HURLEY				14. MOTHER'S MAIDEN NAME MARY HANAHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address RAYMOND LUDWIG, 720 WASH. AVE., CHARLEROI, PA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO cause last.						INTERVAL BETWEEN ONSET AND DEATH HOURS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8-2-60		22c. NAME OF CEMETERY OR CREMATORY CALVARY	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i> ADDRESS OAKLAND, MD.				24a. REC'D BY REGISTRAR DATE AUG 4 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	
22d. LOCATION (City, town, or county) CHARLEROI, PA.				22e. (State) PA.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
STATE		COUNTY		TOWNSHIP		PARISH	
MARRIED		SINGLE		WIDOWED		DIVORCED	
EDUCATION		OCCUPATION		HABIT		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE	
SIGNATURE OF WITNESS		DATE		TIME		PLACE	
SIGNATURE OF JURY		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		DATE		TIME		PLACE	
SIGNATURE OF CLERK		DATE		TIME		PLACE	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE	
SIGNATURE OF JURY		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		DATE		TIME		PLACE	
SIGNATURE OF CLERK		DATE		TIME		PLACE	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE	

(M)

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8028

CERTIFICATE OF DEATH

08016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS Rowlesburg.	
3. NAME OF DECEASED (Type or print) First James Middle M. Last Riggs		4. DATE OF DEATH Month July Day 2 Year 1960.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 10 Days 1 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter-Painter		10b. KIND OF BUSINESS OR INDUSTRY B uilding	11. BIRTHPLACE (State or foreign country) Frostburg, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Riggs	
14. MOTHER'S MAIDEN NAME Malinda Steele		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W W I 3/29/17 to 5/5/17	
16. SOCIAL SECURITY NO. INFORMANT		Address F oster A. Riggs, Oakland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1955 to 2 July, 1960 that I last saw the deceased alive on 2 July , 19 60 , and that death occurred at 7:30 PM from the causes and on the date stated above.	
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Third Street	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE		DATE SIGNED 3 July 60 7/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY Bluemont Cemetery		22d. LOCATION (City, town, or county) (State) Grafton, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ed Liscensc No. 48305		ADDRESS Terra Alta, W. Va.	
24a. REC'D BY REGISTRAR JUL 6 '60		24b. REGISTRAR'S SIGNATURE Charles E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4028

CERTIFICATE OF DEATH

(11-11)

1

Q
R

MEASLES
VIRUS

DECEASED: [Name] [Address] [City] [State] [Zip]

DATE OF DEATH: [Date]

PLACE OF DEATH: [Location]

CAUSE OF DEATH: [Cause]

IMMUNIZATION: [Status]

SIGNATURE: [Signature]

DATE: [Date]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08017

8036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> c. LENGTH OF STAY IN 1b <u>6 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #219, 12 Mi. N. Oakland, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bart.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3326 Texas Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Arlene</u> First <u>Agnes</u> Middle <u>Shumaker</u> Last				4. DATE OF DEATH <u>July</u> Month <u>26,</u> Day <u>19</u> Year <u>60</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1903</u>		9. AGE (In years <small>last birthday</small>) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>for other s</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. T. Akehurst</u>						14. MOTHER'S MAIDEN NAME <u>* Sarah A. ?</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-22-7300</u>				17. INFORMANT <u>Mrs. Arthur R. Morris</u> Address <u>Oakland, Md. Star Route</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO <u>CORONARY SCLEROSIS WITH THROMBOSIS, LEFT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u> </u> </div> <div style="width: 55%;"> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 Hrs.</u> --- </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> 19 <u> </u> Hour <u> </u> a. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>7-26-60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/30/1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u>						ADDRESS <u>Oakland, Md.</u>						24a. REC'D BY REGISTRAR <u>JUL 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 STATE OF MARYLAND
 COUNTY OF BALTIMORE

DECEASED: JOHN J. BROWN
 SEX: MALE AGE: 45
 DATE OF DEATH: 1910
 PLACE OF DEATH: 1234 Main St. Baltimore, Md.
 CAUSE OF DEATH: Heart Disease
 MANNER OF DEATH: Natural
 SIGNATURE OF EXAMINER: [Signature]
 OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MD.



This certificate is to be filed in the office of the Medical Examiner, Baltimore, Md., and a copy thereof to be sent to the office of the Registrar of the State of Maryland, Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8037

08018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, on way to Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Oakland, Md.		d. STREET ADDRESS 85X-2	
3. NAME OF DECEASED (Type or print) First John Middle Paul Last Serafin		4. DATE OF DEATH Month July Day 29 , Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1914
9. AGE (in years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill Work	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Serafin		14. MOTHER'S MAIDEN NAME Mary Augustine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-26-1507	
17. INFORMANT Joseph Serafin		Address Phillippi, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr. few years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED 7-29-60	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/1960	22c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery	22d. LOCATION (City, town, or county) (State) Bayard, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Reighton</i>		24a. REC'D BY REGISTRAR AUG 2 '60	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Housh</i>	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING TO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES A. BROWN, JR.		AGE 35		SEX Male		RACE White		DATE OF DEATH 10-2-1957		PLACE OF DEATH Home	
RESIDENCE 1000 1st St. N.E., Charleston, W. Va.		OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
DATE OF BIRTH 10-2-1922		PLACE OF BIRTH Charleston, W. Va.		PARENTS James A. Brown, Sr. & Mary Ann Brown		SPOUSE Mary Ann Brown		CHILDREN None		PREVIOUS ILLNESS None	
DATE OF EXAMINATION 10-2-1957		PLACE OF EXAMINATION Home		EXAMINER'S SIGNATURE J. A. Brown, Jr.		TESTIFYING PHYSICIAN'S SIGNATURE J. A. Brown, Jr.		TESTIFYING PHYSICIAN'S NAME J. A. Brown, Jr.		TESTIFYING PHYSICIAN'S ADDRESS 1000 1st St. N.E., Charleston, W. Va.	
DATE OF DEATH 10-2-1957		PLACE OF DEATH Home		DECEASED'S SIGNATURE J. A. Brown, Jr.		DECEASED'S ADDRESS 1000 1st St. N.E., Charleston, W. Va.		DECEASED'S PHONE None		DECEASED'S RELATIONSHIP TO EXAMINER None	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY										b. COUNTY									
M Garrett										Maryland Garrett									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Rural Oakland,										Rural Oakland,									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)										d. STREET ADDRESS									
Route 219, 4 Mi. N. Oakland, Md.										Rt. #219, 4 Mi. N. Oakland									
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH									
First Middle Last										Month Day Year									
William Snyder										July 20, 19 60									
5. SEX										6. COLOR OR RACE									
Male										White									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>										8. DATE OF BIRTH									
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										1879									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY									
Farmer										Own Farm									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
Levi Snyder										Martha Ford									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)										16. SOCIAL SECURITY NO.									
no										John Snyder									
17. INFORMANT										Address									
										John Snyder Aurora, W. Va.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:										CORONARY OCCLUSION									
IMMEDIATE CAUSE (a)										DUE TO									
420.1										CORONARY SCLEROSIS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)									
										DUE TO									
										(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?									
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY										20d. INJURY OCCURRED									
Month, Day, Year										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
Hour a.m. p.m.										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
19										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER										DATE SIGNED									
ACTUAL SIGNATURE										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type)										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
JAMES H. FEASTER, Jr. M.D.										July 23, 1960									
22a. BURIAL, CREMATION, REMOVAL (Specify)										22b. DATE THEREOF									
Burial										7/25/1960									
22c. NAME OF CEMETERY OR CREMATORY										22d. LOCATION (City, town, or country) (State)									
Egdon Cemetery										Preston Co., W. Va.									
23. FUNERAL DIRECTOR										24a. REC'D BY REGISTRAR									
ADDRESS										24b. REGISTRAR'S SIGNATURE									
H. C. Leighton										Oakland, Md.									
JUL 26 '60										Arthur S. Kraus									

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Levi Snyder

John Snyder, Attorney, Va.

JAMES H. WELSH, JR., M.D.

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8039

CERTIFICATE OF DEATH

Reg. Dist. No.

08020

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Penna. c. COUNTY Allegheny ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville				c. LENGTH OF STAY IN 1b minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dr. Pedro Rivera's Office				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Steving Last Steving				4. DATE OF DEATH Month July Day 9 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1903	
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months 5 Days 10 Hours 19 Min. 60		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver Pittsburgh Gazette Paper - Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Edward Herbert Steving				14. MOTHER'S MAIDEN NAME Elizabeth Jamison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 167-01-6097			
17. INFORMANT Mrs. Stella Steving (Wife)				Address Pitcairn, Pa. 620 Ninth St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from UNKNOWN , 19 7 , to 7:55P. , 19 7-9-1960 , that I last saw the deceased alive on 7-9-1960 , and that death occurred at 7:55P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Pedro Rivera				ADDRESS (Street, city or town, state) Box L-7 Friendsville Md DATE SIGNED 7-10-60			
PHYSICIAN'S NAME (Type) Dr. Pedro Rivera				Friendsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/1960		22c. NAME OF CEMETERY OR CREMATORY Penn Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Irwin, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUL 11 '60	
24b. REGISTRAR'S SIGNATURE William D. ...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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RE
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8029
CERTIFICATE OF DEATH
08021

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS Rural, one mile So. Oakland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle WEBER Last WEBER				4. DATE OF DEATH Month JULY Day 11 Year 19 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 11, 1871	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 89 Days 11 Hours 11 Min. 19 60		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST				10b. KIND OF BUSINESS OR INDUSTRY Weber Green House		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY WEBER				14. MOTHER'S MAIDEN NAME KATHERINE SCHUTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 1-1808 WEBER		17. INFORMANT DIANA WEBER Address ROUTE # 2 - OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhage - Esophageal Varices DUE TO Advanced Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ascites & Bilateral Pleural Effusion - 3 Months INTERVAL BETWEEN ONSET AND DEATH 4-6 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 20, 1960 to July 11, 1960 that (I) (we) last saw the deceased alive on July 11, 1960 , and that death occurred 8:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE Herbert H. Leighton				22b. DATE SIGNED 11 July 60			
22c. PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				22d. ADDRESS OAK STREET OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/1960		23c. NAME OF CEMETERY OR CREMATORY Weber family Cemetery		23d. LOCATION (City, town, or county) (State) near Oakland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE JUL 14 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barton Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barton Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Baby Boy Wilson		4. DATE OF DEATH Month July Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1960
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lorraine Wilson		14. MOTHER'S MAIDEN NAME Hilda Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lorraine Wilson		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr, 20 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/5 1960 to 7/5 19 60 that (I) met last saw the deceased alive on 7/5 1960 and that death occurred at 1020 AM from the causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM W. LESH		22d. ADDRESS 84 Main St. Westernport Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 6, 1960	
23c. NAME OF CEMETERY OR CREMATORY Bloomington Cem.		23d. LOCATION (City, town, or county) (State) Bloomington Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ed. Boul		ADDRESS Westernport, Maryland	
25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

10-10-11

10-10-11

DATE OF DEATH

PLACE OF DEATH

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